Obama nominates cost-cutting advocate as Medicare and Medicaid chief

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President Barack Obama will appoint Dr. Donald Berwick as the new chief of the Centers for Medicare and Medicaid Services. If approved by the US Senate, Berwick will oversee the health care needs of approximately 100 million people, or 1 in 3 Americans, and be tasked with implementing the changes to Medicare and Medicaid laid out in the health care legislation which passed last month, including a cut of hundreds of billions of dollars to the Medicare budget.

Although he presents himself as a champion of common sense and more effective health care, a little probing reveals that Berwick belongs to the layer of health care professionals pushing for cost-cutting and rationalization of care, in line with the reactionary findings and thinking of the Dartmouth Medical School's Institute for Health Policy and Clinical Practice. The WSWS has recently commented on the Dartmouth study. (See"The Dartmouth Atlas of Health Care study: Shoddy science in support of health care cuts".)

Berwick is a pediatrician and serves as clinical professor of pediatrics and health care policy at the Harvard Medical School and is professor of health policy and management at the Harvard School of Public Health. From 1990 to 1996, he was vice chair of the US Preventive Services Task Force, the organization which in 2009 recommended that women under the age of 50 not undergo annual mammogram screenings, drawing condemnation from large numbers of specialists in the treatment of cancer.

Currently, Berwick is President and CEO of the Institute for Healthcare Improvement (IHI), a non-profit organization whose stated aim is the improvement of patient care and the reform of the health care industry through lowering costs and reducing waste. Both Berwick and the IHI have been widely praised in the media since Berwick's nomination became public.

Berwick has been hailed as a major innovator and a defender of "patient-centered care." His efforts to combat medical errors have been cited repeatedly in the media this week, including his campaign against infections acquired in hospitals due to neglect of sterilization procedures.

However, an examination of IHI studies reveals their policies are not patient-centered, but cost and profit-centered, along the lines proposed by the Dartmouth Institute.

The Dartmouth group's analysis of the health care industry places blame for the high cost of care on doctors and medical facilities which it claims put their patients through unnecessary or excessive tests and treatments. In calling for cuts and penalties for the costliest facilities and financial incentives for the least expensive, Dartmouth's reforms amount to a call for a rationing of health care services which will deprive poor and working class patients of vital tests and medical procedures. Meanwhile the rich will go on getting tested to whatever extent they feel necessary.

Berwick has called the "spending and outcomes" research of the Dartmouth Institute "the most important health-service research of this century." He lamented in *Dartmouth Medicine* that "Not a single leader of a health-care system or a single visible policy-maker has had the courage to take those findings to the next logical step, in either corporate or public-policy planning."

The connection between Berwick and the Dartmouth group is very close. In fact, the co-founder of the Institute for Healthcare Improvement, Dr. Paul Batalden, is the director of the Health Care Improvement Leadership Development (HCILD), part of the Dartmouth Institute.

In a 2009 white paper called "Increasing Efficiency and Enhancing Value in Health Care," the IHI outlines some of its basic conceptions. The paper's executive summary begins, alarmingly, "Until recently, the rationale for health care providers to undertake quality improvement

(QI) initiatives rested largely on 'doing the right thing'". The summary goes on to lay out a strategy in which cost-cutting is the central concern of the reform of health care, calling for "the systematic identification and elimination of waste, while maintaining or improving quality." The paper goes on to say, "Here, the aim is primarily financial; any positive impact on quality, while desired, is secondary."

Another IHI white paper on the "Appropriate Use of Special Services" also takes up this theme, saying "Most physicians are driven by doing what is right for the patient and are not aware of possible overuse in their own practices." This paper repeats the oft made assertion that "as much as 30 percent of health care costs, or approximately $700 billion, could be eliminated without reducing quality," if only cuts to high-cost "overtreating" facilities were made. This is the myth that the Dartmouth researchers, the *New York Times* and Obama's budget director Peter Orszag assiduously spread. (See, "An interview with Dr. Richard Cooper, critic of the Dartmouth Atlas of Health Care research")

Like Dartmouth, the IHI points to data regarding the difference between spending in high-cost and low-cost hospitals in which the quality of care was supposedly the same. Both Dartmouth and the IHI use the dubious numbers at which they arrive, ignoring differences in social conditions and the state of health of poor and wealthy patients, to argue that medical procedures are being overused, patients are being over-tested and over-treated. Hospitals, according to this logic, should be stripped of funding to bring them into line with their more "efficient" competitors.

In a major speech Berwick delivered December 15, 2009 to open the 21st annual National Forum on Quality Improvement in Health Care of the Institute for Healthcare Improvement in Orlando, Florida, he "urged policymakers to create a new system of care that's sustainable." (AMN Healthcare web site) The world has limits, he told his audience, according to the news account.

Berwick claimed, in effect, that while it would be wonderful to provide top quality health care for everyone, that was not a realistic possibility. He alleged that by demanding what is best for each one of them, "rational healthcare stakeholders are eroding a common good, simply doing what makes sense to them individually. In the short term everyone wins, but in the long term, everyone loses. … Healthcare is not entitled to everything it has, and it is surely not entitled to everything it can get."

The AMN Healthcare web site continued, "Berwick encouraged people to determine what it is they truly want, and felt that system could be sustainable in the future. More healthcare does not equal better health. Berwick discussed the Dartmouth Atlas Project, which showed a regional variation in Medicare spending per capita that did not equate spending more with better outcomes."

Then it cited this revealing comment by Berwick: "The best healthcare is the very least healthcare we need to gain the long, full and joyous lives that we really, really want. … The best hospital bed is empty, not full. The best CT scan is the one we don't need. The best doctor visit is the one we don't need to have."

At no point does either Berwick or the IHI suggest that access to quality health care is a basic democratic right. Their work, while claiming to be patient-centered, dutifully lines up on the side of insurance companies and private hospital chains.

Given the views central to the IHI and the recommendations for reforms outlined in their research, one must say that Donald Berwick is the perfect man for the job of cutting Medicaid and Medicare. And in Barack Obama, Berwick has finally found the man with the political will to "take those [Dartmouth] findings to the next logical step."

Like Obama before him, the liberal press, with the *New York Times* in the forefront, will hold Berwick up as an agent of rational and progressive reform, when, in reality, he will play a leading role in implementing a reactionary assault on health care in the United States.